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ABSTRACT

The two-year process of establishing and implementing a by-mail outcome evaluation system in a community mental health center is described. The effect of active executive leadership and the subsequent effects of staff cooperation on client participation rates are discussed, as well as specific responsibilities of the program manager. Illustrative program outcome results are also reported. (Author)

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Effects Of Executive Policy On Client Consent

And Participation Rates, And
Exemplifying Outcome Results¹

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Much has been written and said, in the way of advice to Program Evaluators, about the organizational politics and strategies of successful implementation of evaluation research in service delivery settings. Coursey, in 1977, has stated that "...successful implementation of an evaluation project is more a function of navigating the human and organization complexities and resistances....than it is a matter of technique and methodology". Evaluators often find themselves in the unenviable position of being expected to assure organizational compliance with external evaluation requirements, such as those of HEW, and having to try to politic, sell, conjoin, manipulate, and/or seduce management and line staff into assisting with the required data collection. That this is often the case with outcome or effectiveness evaluation seems at least in part a result of executive level uncertainty, ambivalence, and lack of leadership. Zinober, in 1977, has commented that: "A crucial key to the success of any evaluation program is the attitude and accessibility of the center's director".

I am now going to share with you a roughly two year chronicle demonstrating the effects of executive policy and decisions on client consent and participation rates in outpatient outcome evaluation. The basic procedures involved are largely by-mail collection of data from the "significant others" of clients, and by-mail collection of three-month follow-up data from clients themselves. The by-mail model was

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selected for cost reasons, as enumerated by Schainblatt in 1977. The setting is a largely rural, five county CMHC catchment area in South Central, Indiana; the catchment area has a population of 147,000 and the largest city, Columbus, has a population of roughly 30,000 people. The basic services are provided in Columbus, with additional outpatient clinics in all of the other four outlying counties in the catchment area. The initial focus will be on client participation rates because of the still largely unresolved problems of clients self-selecting themselves "out" of participation in outcome evaluation, sample bias, and problems with inferences and conclusions about program impact.

Our story begins in the late winter and spring of 1976, during a period between the resignation of one executive director and the arrival of another, July 1, 1976. A Program Evaluation Advisory Committee consisting of line staff members had been established. After completion of a pilot study of the Denver Community Mental Health questionnaire as a measure of outpatient service impact had been completed, the committee decided to recommend piloting of Ellsworth's Personal Adjustment and Role Skill Scales (PARS); the PARS questionnaires completed by the clients "significant other", either a family member or a close friend, at the time of admission to service and again three months later when used with an outpatient population. The committee also recommended that Quinco assist Ellsworth in obtaining standardization data on a new self-administering questionnaire, the Profile of Adaptation To Life (PALS), from an outpatient population. These recommendations were presented to the clinical staff and to an interim executive committee. Emphasis was placed on the fact that data was not to be used in personnel evaluation, but only for studying average service effects. The proposal was met with neither overt resistance nor massive exuberance on the part of the clinical staff; the dominant tone was that a permissive but somewhat

guarded acceptance of the undertaking. The interim executive committee gave formal permission to conduct the study. In retrospect it is important to note that this was permission rather than a mandate to measure service effectiveness.

It should be noted too, that the new executive director specifically defined, the evaluator's role as that of a consultant to program managers. Thus, the evaluator had no authority over service or secretarial personnel outside of his own two assistants.

The initial procedures for presenting the questionnaire to clients, and for obtaining their consent for the PARS to be sent to a "significant other", and consent to send the PALS to them three months later, were developed with a prominent attitude of not imposing on clients and attempting to avoid a sense of coercion. When a client is admitted to outpatient service, he meets the outpatient secretary prior to his first interview (except in the case of emergency situations), and the outpatient secretary obtains the basic background and face sheet information. This outpatient secretary also presented the evaluation consent forms to the client at this time, and if he agreed to participate, also administered the admission PALS questionnaire. The consent forms were then passed on to the Program Evaluation Department from which the PARS questionnaires were sent to the "significant others" and the PALS to the client three months hence. Thus, data collection began in the summer of 1976 in the central office, but not in the county satellite clinics. Each mailing was followed by a second "reminder" questionnaire one week later to those individuals who had not returned the initial questionnaire.

As the first few months passed, and data and consent forms only trickled in, we began closer monitoring of the presentation and consent obtaining process. This monitoring revealed that only about one-third of the clients were consenting and participating, but about one-third

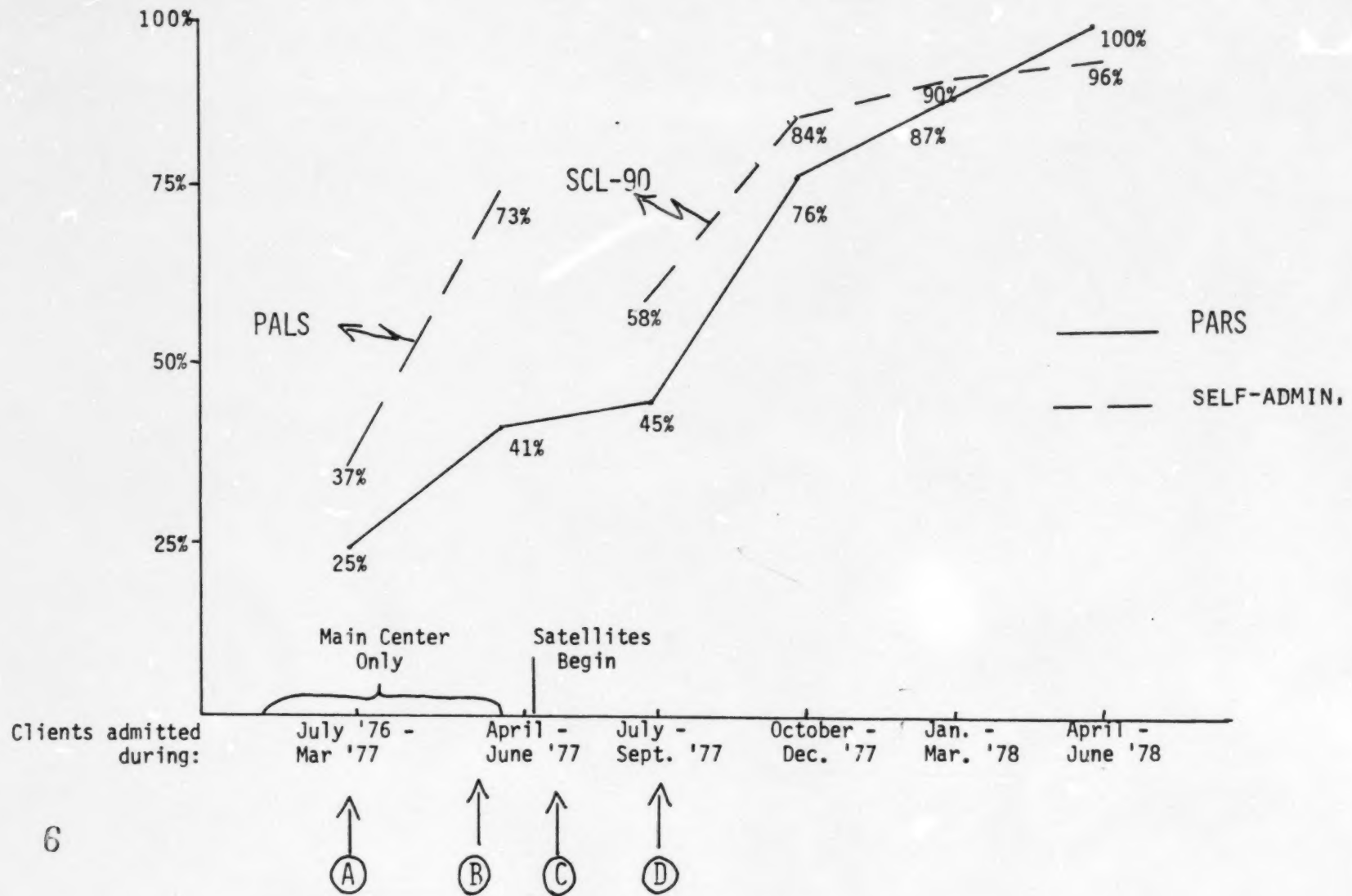
were refusing, and about one-third were not even being asked to participate. A quick check with Bob Ellsworth indicated that this high a refusal rate was not consistent with his experience, nor was it consistent with our own subsequent experience. Further investigation revealed two problems.

1. The outpatient secretary, out of her concern for clients' feelings and reactions, was simply not asking some clients to participate, and was giving other clients covert but strong permission not to participate. The covert messages took the form of, "This really isn't important", and "You really don't have to do this". This behavior came from a sense of imposition on the clients.
2. The second problem involved a few clinical staff who simply did not bother presenting the consent forms and questionnaire to those clients whom they admitted to outpatient service without the assistance of the outpatient secretary; that is, after 5:00 P.M. and in emergency situations.

The first problem fortuitously resolved itself just prior to the evaluator's frustration level reaching the explosion threshold in February, 1977. This occurred when the outpatient secretary resigned to take another position. This did, however, present the opportunity of vigorously incorporating program evaluation responsibilities in the job description of the new secretary, and to give her close supervision during her first weeks on the job. The new secretary was much more comfortable with a "matter-of-fact", and "this is part of the standard routine" approach to presenting the consent forms and procedures to clients.

(First figure about here) This difference in attitude is reflected in the differences in consent rates between the first 9 months of FY-77 as exemplified in the first data point on this graph and the last three months of FY-77 as indicated by the second data point on the graph.

OUTPATIENT CLIENT CONSENT RATES



Point "A" designates the arrival of the new secretary.

These events helped, but did not solve the second problem.

Repeated verbal and written requests from the evaluator to the clinical staff and to the outpatient team managers had no effect on clinical staff consistently presenting the evaluation procedures to new clients who for one reason or another, bypassed the outpatient secretary, or supporting the evaluation to those clients who initially seemed hesitant or refused to consent. The result was that we obtained complete admission and three-month follow-up data from only about 12 to 15 percent of newly admitted clients during FY-78.

Thus, in June, 1977, at point "B" on the graph, I reviewed this situation with the executive director, emphasizing the high attrition rates, the possibly biased data, the relatively low net data yield, the approximately \$45,000 evaluation budget, and our ethical obligation to attempt to measure impact and effectiveness of services. I also recommended that program managers be made ultimately responsible for obtaining client consent and admission self-description data, because of their administrative control of outpatient secretaries and line staff. I suggested that all program managers have at least one outcome objective in their annual MBO plan.

The executive director agreed that we were obligated to be concerned about the effectiveness of our services. He then convened a meeting of all service program managers in early July, 1977; point "C" on the graph, and after a rather lengthy and somewhat tense discussion about measuring effects of service, mandated that all program managers were to begin systematically monitoring the effectiveness of their services in some way. The three main components of his mandate were:

1. Program managers were ultimately responsible for evaluating their services, and therefore responsible for facilitating

obtaining client consent and participation;

2. They were free to choose whatever measures best reflected the purposes of their programs in consultation with the evaluator; and:
3. FY-78 was to be viewed as a pilot or trial year, to develop procedures, test instruments, and establish baselines, with the intent of defining MBO outcome objectives for FY-79.

At this point, I am still limiting my remarks about the development of procedures to the outpatient department, because it is this area that has the least influence (control) over client behavior, and is thus most problematic from the standpoint of obtaining client cooperation and participating in studying and documenting short-term service impact. It was also the outpatient team managers who most vigorously "bit the bullet" in increasing consent and admission data collection rates.

At a planning meeting with the outpatient managers in early September, 1977, point "D" on the graph, it was decided to focus initially on increasing client consent and admission participation rates.

The managers thus set objectives for themselves of getting the PARS consent rates up to 75%, and admission completion and consent for three-month follow-up rates for the Hopkins SCL-90 up to 80% by January 1, 1978 (standardization data for the PALS had been completed in June of 1977, and managers had decided to test the Hopkins symptom checklist 90, using general public norms, as a self-report measure of symptomatology beginning July 1, 1977). Specific procedures developed to accomplish these consent and completion rate objectives included:

1. Redrafting the instructions for secretarial presentation of evaluation forms to clients, and the written explanations to clients on the consent forms, emphasizing much more directly the importance and the expectation of their participation

in evaluation, and our legal obligation to evaluate impact because of our receiving federal money. This change followed from a significant change in managerial attitude that clients "were to participate" in evaluation procedures, and that a client's "just not wanting to" was not a good enough reason for their nonparticipation.

2. Instructing staff therapists to review and discuss with clients the reasons for refusing consent and offering appropriate additional information and encouragement to hesitant clients, to the extent it was clinically appropriate to do so. The necessity of the therapist doing this with a given client was signaled by the outpatient secretary attaching a colored slip of paper to the client's chart before the therapist saw the client for the first time. It was left to the therapist's clinical discretion when and how vigorously to pursue this issue with the client.
3. Semi-weekly reporting of consent and SCL completion rates to the managers, by team, and the rates among clients of individual therapists to the individual therapists in comparison to all clients. These data were reported in time-series fashion to show change over time.
4. Development of forms for secretaries and therapists to use in explaining/justifying a client's nonconsent or nonparticipation. Lack of an adequate explanation was counted as a consent "failure" against the therapist and his team.
5. Tightening the definition of legitimate "exclusions" from participation: these included, client's being admitted directly to the inpatient, partial hospitalization, or halfway house

programs, because these programs were to have their own evaluation procedures; blatantly psychotic and/or extremely hysterical clients; visually or cognitively impaired clients; clients coming only for diagnostic evaluations such as OVR or mental retardation service agencies; clients who are literally panicked about a spouse of someone else knowing that they were receiving mental health services; and those alienated and socially isolated clients who literally had no one who knew them well or saw them on a daily basis. However, clients being seen on an emergency basis were not automatically excluded from participation.

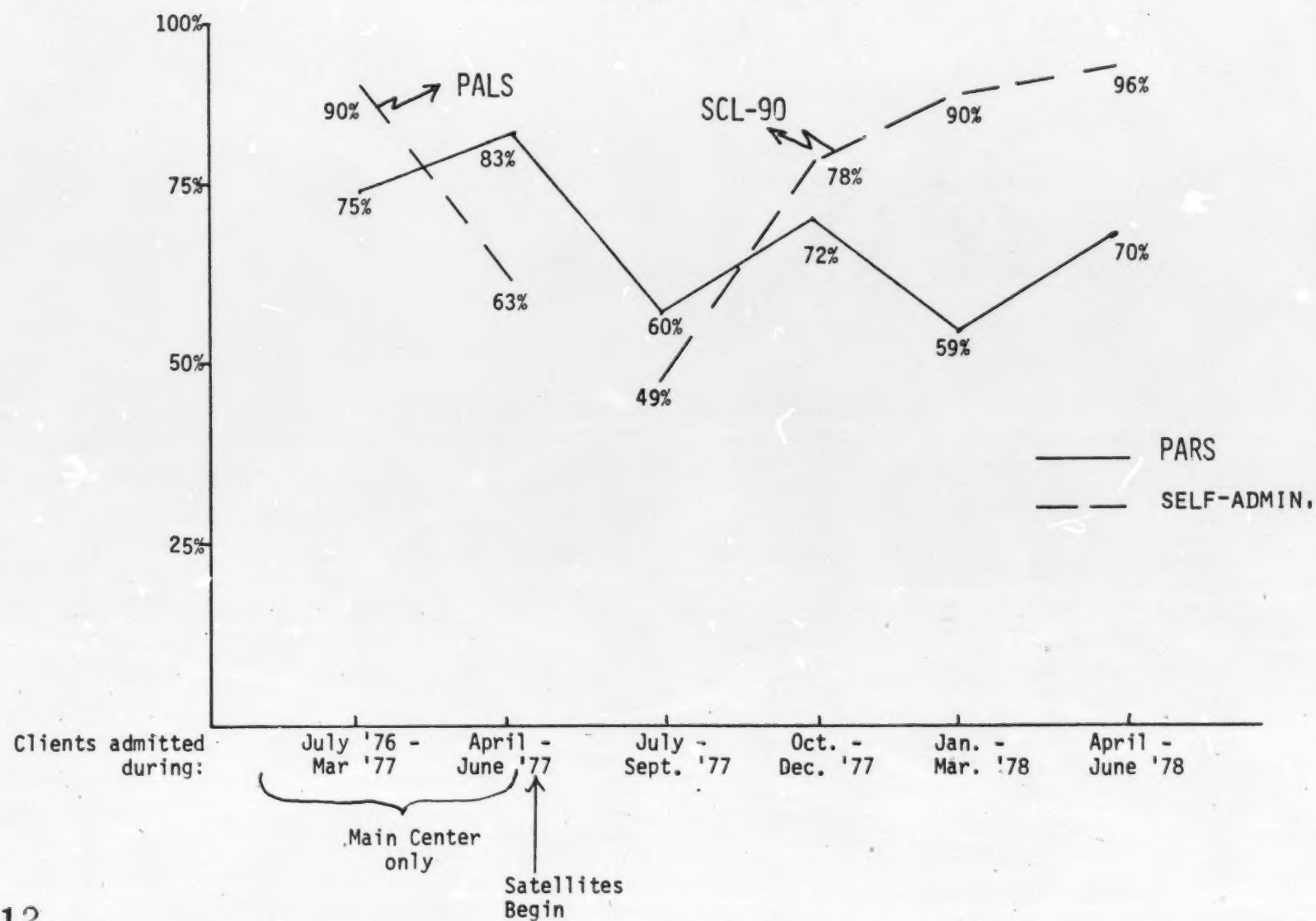
6. A third reminder mailing to people who had not returned the questionnaire was initiated.

These procedures were implemented in October, 1977, and continued through November and December, with SCL consent rates improving from 53% to 84%, and PARS consent rates from 45% to 76%, between the first and second quarters of FY-78. The outpatient managers objectives for consent and admission SCL completion rates were achieved by January 1, 1978 (note: during December, the rates exceeded the 75 and 80% criteria; the data in the graph is the total for the quarter). Beginning in the winter of 1978, feedback of our rates to managers and therapists was backed off to monthly and eventually to semi-monthly reporting. Interestingly, once the staff attitudes and behavior patterns had been modified, the consent rates continued to improve with no additional procedural changes (note the rates for the quarters ending in March and June, 1978).

Briefly, the initial pretreatment completion rates for the PARS and the self-report instruments are reported in figure 2.

(Figure 2 about here) It is probably noteworthy that as the PARS consent rates rose during FY-77 and the first quarter of FY-78, the admission return rates by "significant others" decreased somewhat. Our

PRE-TREATMENT COMPLETION RATES



admission return rates, with three mailings, during FY-78, have stabilized in the 60-75% range.

Figure 3 depicts the three-month follow-up return rates among clients and "significant others" who returned the admission forms.

(Figure 3 about here) These rates hover around the 50% level in this population of outpatients and their "significant others".

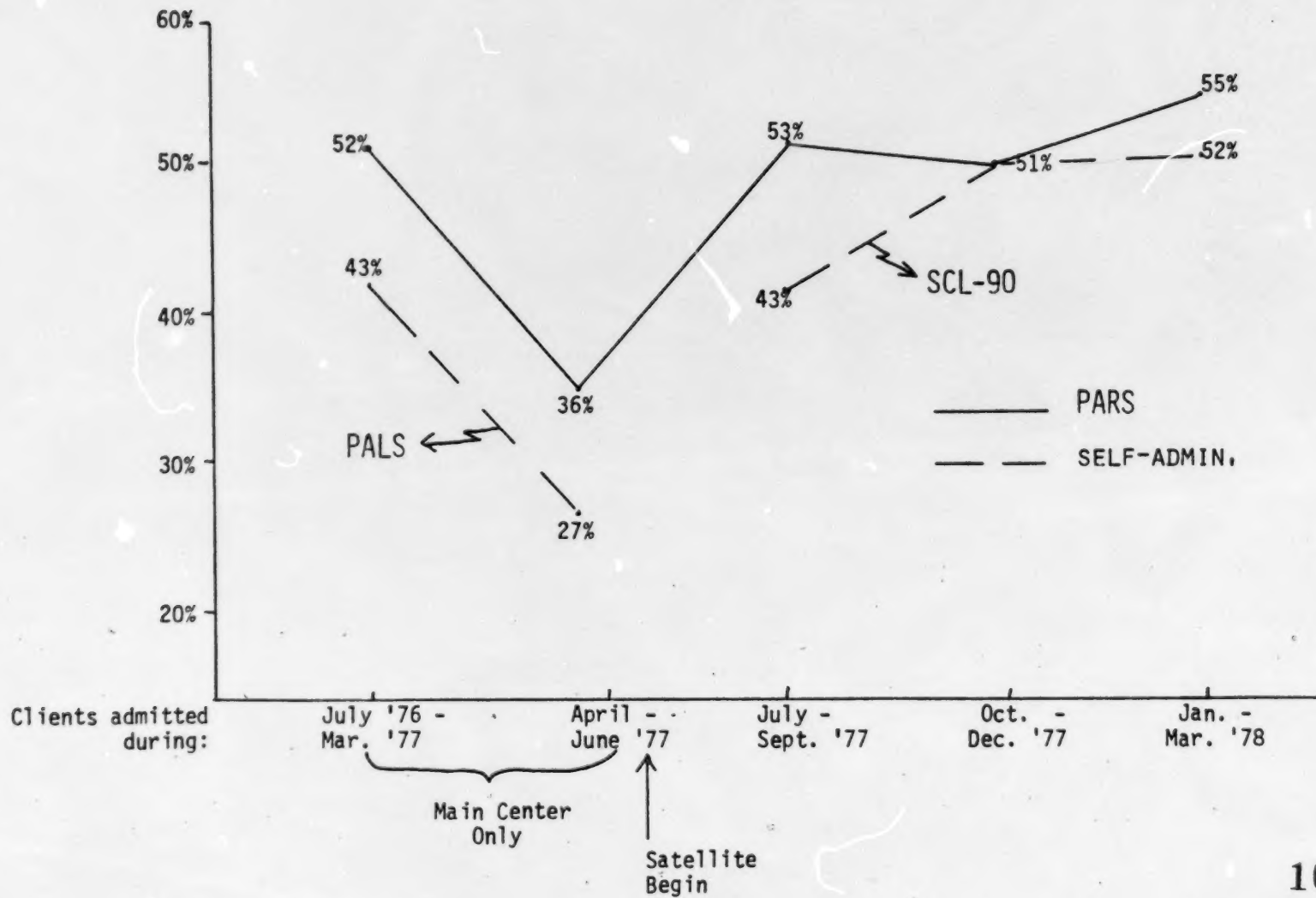
Figure 4 depicts the "final yield" rates; that is, the percentages of all eligible clients from or about whom we received consents, and complete admission and follow-up questionnaires. As the graph indicates, "final yield" rates tripled between the first three-quarters of FY-77 and the third quarter of FY-78.

(Figure 4 about here) Nonetheless, we are only receiving complete self-report symptom data from about 40% of clients, and complete "significant other" ratings on 27% of outpatients. We are hoping these figures will improve as we continue to debug our by-mail follow-up procedures.

Comparisons of Quinco outpatient consent, completion, and final yield rates, with those of several inpatient, by-mail follow-up projects around the country, as reported by Schainblatt, are presented in Table I. Note that these Quinco data are largely from the developmental period, and thus depict lower rates than suggested by later data. These are being shown for comparison purposes because it is from this sample that I will be sharing some outcome results with you in a moment. The Quinco outpatient final yield rates are somewhat, but not markedly lower than those of the various inpatient projects.

(Table I about here) The biggest differences are among the return/completion rates of the admission self-report questionnaire, and the return rates of the three-month follow-up questionnaires by "significant others".

THREE-MONTHS FOLLOW-UP COMPLETION RATES



"FINAL YIELD" RATES

(PERCENT ALL ELIGIBLE CLIENTS PROVIDING
BOTH PRE- AND 3 MOS. DATA)

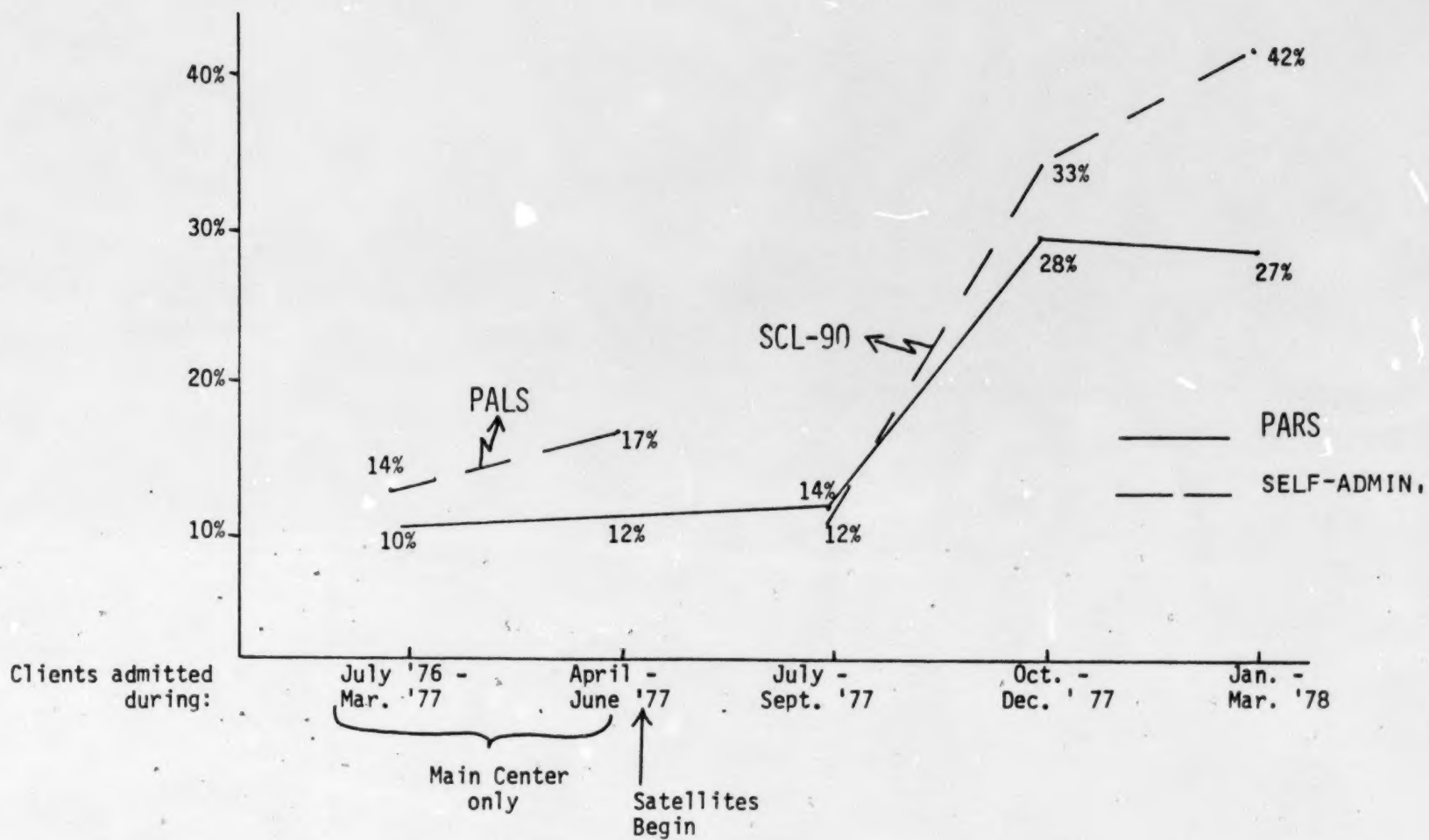


Table 1.

COMPARISON of QUINCO OUTPATIENT CONSENT/COMPLETION RATES
with MH INPATIENT PROGRAMS(from Schainblatt,^a 1977)

	Missouri, Inpatient Significant Others	California Inpatient Significant Others	VA COOP Study Significant Others	Inpatient <u>Self</u> <u>Report</u>	Quinco, ^b Outpatient	
					Significant Others 100%	<u>Self</u> <u>Report</u> 100%
(A) Eligible for Study	100%	100%	100%	100%		
(B) Provided consent and/or Significant Other	81%	66%	67%	86%	78%	84%
(C) Returned Admission Questionnaires	73%	63%	80%	100%	71%	79%
(D) Returned Follow-up Questionnaires	70%	79%	58%	45%	48%	49%
(E) Overall "final yield" (B) x (C) x (D)	41%	33%	31%	39%	27%	33%

^a Schainblatt, Alfred. Monitoring the Outcomes of State Mental Health Treatment Programs:
Some Initial Suggestions. Urban Institute, Washington, D.C., 1977, p. A-4

^b For the preliminary test/analysis period, clients admitted Oct. '77 - Jan. '78.

In summary, these data support the conclusions that:

1. An executive decision to measure service effectiveness is one way to obtain significant middle management and line staff cooperation and assistance in obtaining outcome data;
2. That such executive decisions ultimately and significantly reduce consent and admission data attrition, thus increasing proportions of outpatients from or about whom data is obtained;
3. With sensitive and modest behavior on the part of evaluation personnel, this can be accomplished without mutiny, revolt, or massive hostility on the part of the staff. Parenthetically, there was some significant grumbling and mild resistance among the staff during the developmental period in the fall of 1977, and early winter of 1978. This, stemmed largely from the imposition of additional procedures super imposed upon recently imposed other procedures by JCAH and the State Department of Mental Health.

As the procedures have become routinized, and staff has discovered that they are not being "hung" on outcome results, this dissatisfaction has completely disappeared.

Now, briefly, here are some of the actual outcome data from among outpatients admitted during October, 1977, through January, 1978.

(Figure 5 about here)

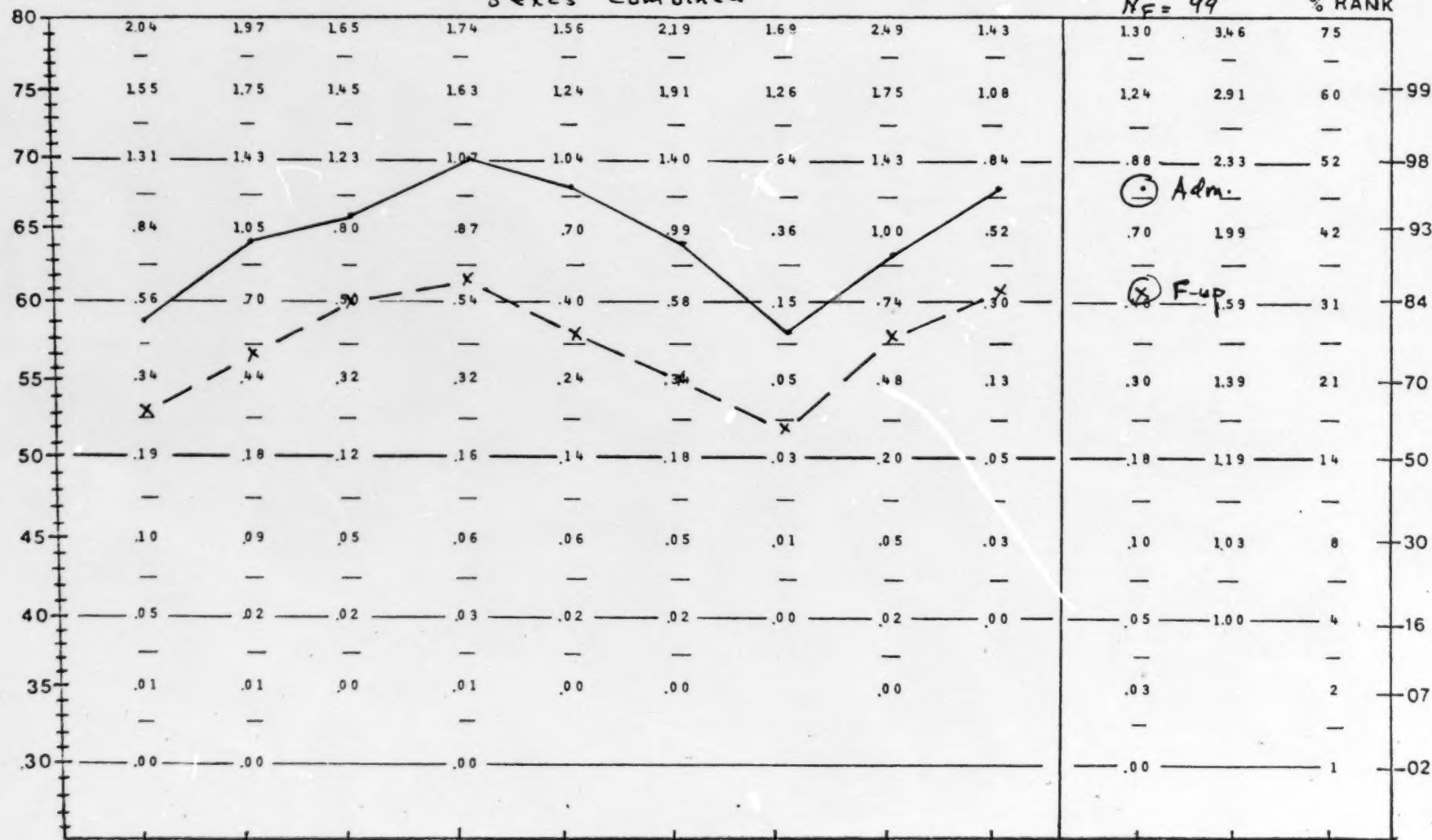
Figure 5 reports mean admission SCL scale data for 200 clients, and mean three-month follow-up data from 99 outpatients. t tests for correlated data from 84 clients indicated that the mean admission follow-up differences were all statistically reliable at the P less than .01 level or less. Note that the follow-up mean score has generally approached the general public norm, with inter-personal sensitivity, de-

SCL-90 SYMPTOM PROFILE Outpatient Admission and 3-months Follow-up Averages Sexes Combined

NA = 200
 NF = 99

% RANK

T - SCORE



% Adm.

≥ 70

SOM

O-C

I-S

DEP

ANX

HOS

PHOB

PAR

PSY

(SI

PSDI

PST

15%

29%

41%

50%

45%

36%

20%

32%

43%

45%

Stat. Sign.

A-F Diff.

All significant at P<.01 level or less

(N=84)

23

pression, and psychoticism remaining in the "mild" problem range (equal to or greater than 60).

The next figure depicts the mean three-months PARS change scores for 32 male and 31 female outpatients. It is reassuring that these profiles approximate the outpatient norm of 50. The outpatient managers are not concerned about the appreciably below average improvement among males on household management.

The next table reports mean three-month follow-up SCL data by county outpatient team. As indicated, there were no reliable differences among the teams at admission, nor at three-month follow-up.

The next table is an analogous breakout of the mean PARS change scores by outpatient team. The team managers were quite reassured by these findings of no reliable differences among the teams on two independent measures of outcome.

Finally, the outpatient admission/follow-up and inpatient admission/discharge SCL data, for clients who provided both, were run through the recent Edwards, Et al, ⁽¹⁹⁷⁸⁾ statistical procedure for judging of the "improvement" or "deterioration" of individual client's follow-up scores relative to their admission scores, at the 95% confidence level. The procedure is based on test-retest reliability, estimated actual admission score, standard errors, and confidence zones.

(Table 4 about here) Table 4 suggests inpatient improvement rates generally in the 50% to 75% range, with a notable exception of paranoid ideation. Outpatient improvement rates, on the other hand, are generally in the 30-45% range with a couple of exceptions. The outpatient team managers are not very pleased with these data. Other than in part reflecting the statistical stringency of the test, we are not quite sure what these data mean, other than possibly about 35% of outpatients report dramatic

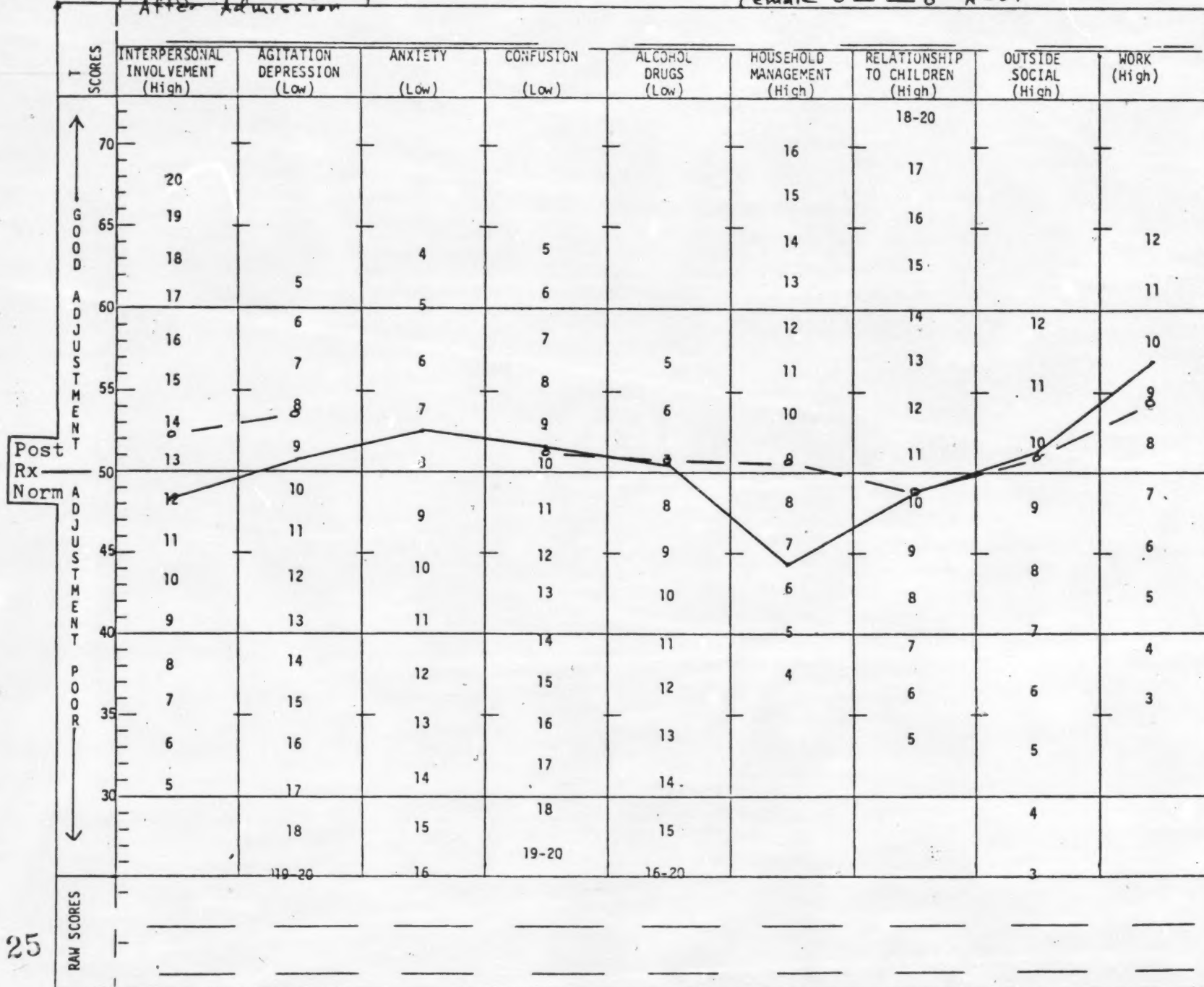
Outpatient Clinic Average Ratings
by "Significant Others" 3 Months
After Admission

PARS V PROFILE----

Female 0 — 0

N=32

N=31



Weighted
Average

⊙ Women
⊗ Men

THREE-MONTH FOLLOW-UP SYMPTOMS OF CLIENTS
SEEN BY THE OUTPATIENT TEAMS*

<u>Scale</u> (N's)	<u>Brown</u> (21)	<u>Decatur</u> (29)	<u>Jackson</u> (20)	<u>Jennings</u> (20)	<u>Statistical</u> <u>Significance</u>
Physical Signs of Distress	51.8	54.0	51.9	55.5	N.S.
Obsessive Compulsive	57.8	55.4	58.6	58.8	N.S.
Feelings of In- security and Inferiority	60.3	57.4	61.1	62.5	N.S.
Depression	63.5	60.0	61.2	64.9	N.S.
Anxiety	58.9	55.7	59.6	61.3	N.S.
Hostility	55.2	51.6	60.3	55.6	N.S.
Phobic/Anxiety	50.3	51.8	50.2	54.9	N.S.
Suspiciousness and Distrust	57.3	54.4	59.8	62.7	N.S.
Strange and Bizarre Experiences	61.5	59.4	61.5	62.8	N.S.
Global Severity Index	62.5	58.1	61.3	61.3	N.S.

*NOTE: 50 is the average for the general public, and scores of 70 or more indicate "significant" problems. There were no differences between clients seen by the different teams at admission.

CHANGE RATINGS BY "SIGNIFICANT OTHERS"
OF CLIENTS SEEN BY THE OUTPATIENT TEAMS*

<u>Scale</u> (N's)	<u>Brown</u> (14)	<u>Decatur</u> (19)	<u>Teams</u> <u>Jackson</u> (10)	<u>Jennings</u> (11)	<u>Statistical</u> <u>Significance</u>
Interpersonal Involvement	47.5	51.1	51.8	50.8	N.S.
Agitated Depres- sion/Anxious Depression	51.6	54.8	52.5	49.3	N.S.
Confusion	50.6	52.6	51.4	49.4	N.S.
Alcohol/Drugs	52.3	47.8	53.5	51.4	N.S.
Household/ Management	46.7	47.9	46.6	48.1	N.S.
Relationship with Children	46.5	48.7	48.8	49.9	N.S.
Outside Social Activities	52.8	49.8	50.5	54.2	N.S.
Work	54.5	53.6	60.7	58.9	N.S.
Weighted Average	50.6	51.9	52.3	50.9	N.S.

*NOTE: 50 is the average improvement among clients seen in Outpatient Clinics around the nation. Scores above 50 indicate greater than average improvement, and less than 50 less than average improvement.

PERCENTAGES OF CLIENTS "IMPROVED" AND "DETERIORATED"
 BY PROGRAM AND KIND OF SELF-REPORTED SYMPTOMS:
 RESULTS OF A SEVERE TEST OF CLIENT IMPROVEMENT

	INPATIENT (N=29)		OUTPATIENT (N=84)	
	%Improved	%Deteriorated	%Improved	%Deteriorated
Physical Signs of Distress	77%	0	39%	2%
Obsessive-Compulsive	56%	4%	37%	4%
Feelings of Insecurity and Inferiority	63%	0	34%	4%
Depression	64%	0	25%	5%
Anxiety	64%	4%	43%	4%
Hostility	50%	0	42%	5%
Phobic Anxiety	70%	0	55%	4%
Suspiciousness and Distrust	32%	4%	41%	4%
Strange and Bizarre Experiences	48%	0	41%	7%
Global Severity Index	68%	0	36%	5%

symptom state reduction 3 months after admission; the sample does include clients who may have come for only one or a few outpatient visits. The average length of stay on the inpatient during this data period was about two and a half weeks.

These, then, are some of the baseline type results of a developing service effectiveness measuring program in a community mental health center. Data collection procedures are in place and the staff has been largely desensitized to the process. We are now in the process of deciding which are the most managerially relevant ^{and} useful directions to go from here.

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